



STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Enrollment Questionnaire



<input type="checkbox"/> New Provider			<input type="checkbox"/> Individual Provider <input type="checkbox"/> Group Provider		
Provider Name:					
Street Address:					
City:		State and Zip:		Phone: ()	
Contact Name:				Title:	
Enrollment Reason: <input type="checkbox"/> Anticipating or Currently Providing Services <input type="checkbox"/> Provided Services <input type="checkbox"/> Business expanding into Rhode Island <input type="checkbox"/> Other: _____					
Services Provided: <input type="checkbox"/> Emergency <input type="checkbox"/> Urgent <input type="checkbox"/> Elective					
Number of Rhode Island Medicaid recipients you treat or anticipate treating annually:					
If enrollment based on contact with a specific recipient, please provide information in the boxes below:					
Recipient Name:			Diagnosis Code:		
Medicaid ID Number:			Dates of Service:		
Recipient Date of Birth:					
Reimbursement Sought: <input type="checkbox"/> Medicaid Only <input type="checkbox"/> Medicare Co-Pay <input type="checkbox"/> Other Insurance Co-Pay					
Name of Other Insurance:					

*****OFFICE USE ONLY*****

Enrollment Approved: _____ to _____	
Enrollment Rejected:	
Reason for Rejection:	
EOHHS Approval:	Date: